

		FOR OHF USE					

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2002  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2002)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div>I. IDPH Facility ID Number: 0016634</div> <div>Facility Name: CLAYTON RESIDENTIAL HOME</div> <div>Address: 2026 N. CLARK STREET CHICAGO 60614</div> <div>County: COOK</div> <div>Telephone Number: (773) 549-1840 Fax # (773) 549-2036</div> <div>IDPA ID Number: 362607443001</div> <div>Date of Initial License for Current Owners: 00/00/69</div> <div>Type of Ownership:</div> <div><div><div>VOLUNTARY,NON-PROFIT</div><div><div>Charitable Corp.</div><div>Trust</div></div><div>IRS Exemption Code</div></div><div><div>X PROPRIETARY</div><div><div>Individual</div><div>Partnership</div><div>Corporation</div><div>X "Sub-S" Corp.</div><div>Limited Liability Co.</div><div>Trust</div><div>Other</div></div><div><div>GOVERNMENTAL</div><div><div>State</div><div>County</div><div>Other</div></div></div></div><div><div>In the event there are further questions about this report, please contact:</div><div>Name:: Steve Lavenda Telephone Number: (847) 236 - 1111</div></div></div>	<div>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</div> <div>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</div> <div>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</div> <div><div>Officer or Administrator of Provider</div><div>(Signed) (Date)</div><div>(Type or Print Name)</div><div>(Title)</div></div> <div><div>Paid Preparer</div><div>(Signed) See Accountants' Compilation Report Attached (Date)</div><div>(Print Name and Title) RICHARD S. SGARLATA, C.P.A.</div><div>(Firm Name &amp; Address) Frost, Ruttenberg &amp; Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</div><div>(Telephone) (847) 236-1111 Fax # (847) 236-1155</div><div>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div></div>
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SEE ACCOUNTANTS' COMPILATION REPORT

#	0016634	Report Period Beginning:	01/01/02	Ending:	12/31/02
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**D. How many bed-hold days during this year were paid by Public Aid?**

N/A

**2,005** (Do not include bed-hold days in Section B.)

None

**Yes**

YES ☐ NO ☒

YES ☐ NO ☒

**Date started** 11/28/66

YES ☐ Date \_\_\_\_\_ NO ☒

YES ☐ NO ☒ If YES, enter number  
of beds certified and days of care provided

## Medicare Intermediary

ACCRUAL	X	MODIFIED CASH*		CASH*	
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Is your fiscal year identical to your tax year? YES ☒ NO ☐

**Tax Year:** 12/31/02      **Fiscal Year:** 12/31/02

**\* All facilities other than governmental must report on the accrual basis.**

## SEE ACCOUNTANTS' COMPILATION REPORT

1		2		3		4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period			
1		Skilled (SNF)				1	
2		Skilled Pediatric (SNF/PED)				2	
3	252	Intermediate (ICF)	252	91,980		3	
4		Intermediate/DD				4	
5		Sheltered Care (SC)				5	
6		ICF/DD 16 or Less				6	
7	252	TOTALS	252	91,980		7	

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	86,201	120		86,321	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	86,201	120		86,321	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 93.85%

**93.85%**

Facility Name & ID Number CLAYTON RESIDENTIAL HOME # 0016634 Report Period Beginning: 01/01/02 Ending: 12/31/02

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	206,004	28,002	12,750	246,756		246,756		246,756			1
2	Food Purchase		363,430		363,430	(9,928)	353,502	(5)	353,497			2
3	Housekeeping	299,935	47,633		347,568		347,568		347,568			3
4	Laundry		19,278	105,217	124,495		124,495		124,495			4
5	Heat and Other Utilities			163,020	163,020		163,020	1,581	164,601			5
6	Maintenance	119,337		105,805	225,142		225,142	(143)	224,999			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	625,276	458,343	386,792	1,470,411	(9,928)	1,460,483	1,433	1,461,916			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,365,087	38,133	11,181	1,414,401		1,414,401		1,414,401			10
10a	Therapy											10a
11	Activities	119,134	21,435		140,569		140,569		140,569			11
12	Social Services	447,586		63,236	510,822		510,822		510,822			12
13	Nurse Aide Training											13
14	Program Transportation			10,450	10,450		10,450		10,450			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,931,807	59,568	87,267	2,078,642		2,078,642		2,078,642			16
	<b>C. General Administration</b>											
17	Administrative	313,702		858,190	1,171,892		1,171,892	(858,190)	313,702			17
18	Directors Fees			240,000	240,000		240,000	(150,000)	90,000			18
19	Professional Services			38,876	38,876		38,876	(5,582)	33,294			19
20	Dues, Fees, Subscriptions & Promotions			37,764	37,764		37,764	(21,728)	16,036			20
21	Clerical & General Office Expenses	588,195	2,279	91,158	681,632		681,632	(211,254)	470,378			21
22	Employee Benefits & Payroll Taxes			548,805	548,805	9,928	558,733		558,733			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,229	7,229		7,229	(5,737)	1,492			24
25	Other Admin. Staff Transportation			1,934	1,934		1,934	(837)	1,097			25
26	Insurance-Prop.Liab.Malpractice			177,007	177,007		177,007	145	177,152			26
27	Other (specify):*							2,010	2,010			27
28	<b>TOTAL General Administration</b>	901,897	2,279	2,000,963	2,905,139	9,928	2,915,067	(1,251,173)	1,663,894			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,458,980	520,190	2,475,022	6,454,192		6,454,192	(1,249,740)	5,204,452			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			103,894	103,894		103,894	48,368	152,262			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			196,022	196,022		196,022	(58,222)	137,800			32
33	Real Estate Taxes			238,210	238,210		238,210	4,875	243,085			33
34	Rent-Facility & Grounds			30,194	30,194		30,194	(12,833)	17,361			34
35	Rent-Equipment & Vehicles			22,046	22,046		22,046		22,046			35
36	Other (specify):*			47,953	47,953		47,953		47,953			36
37	TOTAL Ownership			638,319	638,319		638,319	(17,812)	620,507			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,970	137,970		137,970		137,970			42
43	Other (specify):*			92,423	92,423		92,423		92,423			43
44	TOTAL Special Cost Centers			230,393	230,393		230,393		230,393			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,458,980	520,190	3,343,734	7,322,904		7,322,904	(1,267,552)	6,055,352			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	48,368	30		9
10	Interest and Other Investment Income	(78,641)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1)	21		18
19	Entertainment				19
20	Contributions	(17,681)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	21		24
25	Fund Raising, Advertising and Promotional	(11)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,179,232)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,287,203)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	19,651		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 19,651		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (1,267,552)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
CLAYTON RESIDENTIAL HOME			
ID# 0016634			
Report Period Beginning: 01/01/02			
Ending: 12/31/02			
NON-ALLOWABLE EXPENSES			Sch. V Line
			Amount Reference
1	II. Council on LTC (COPE)	\$ (4,078)	20 1
2	Risk Management Fees	(6,000)	19 2
3	Meals & Entertainment	(5,232)	24 2
4	Traut Fees	(200)	21 4
5	Management Fees	(858,190)	17 5
6	Non-Allowable Director Fees	(159,000)	18 6
7	Non-Allowable Office Salaries	(151,149)	21 7
8	Miscellaneous Income	(2811)	21 8
9	Painting & Decorating	(3,312)	06 9
10	Deferred Maintenance	552	06 10
11	Travel Expense	(837)	25 11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49			49
50			50
51			51
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80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(1,179,232)	101

## Summary A

12/31/02

[illegible]

## Summary B

12/31/02

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	BARTON MANAGEMENT INC.	100.00%	\$ 1,581	\$ 1,581	15
16	V	6	REPAIRS AND MAINT.		BARTON MANAGEMENT INC.		2,617	2,617	16
17	V	20	DUES, FEES, SUBSCRIPTIONS		BARTON MANAGEMENT INC.		8	8	17
18	V	21	CLERICAL AND GENERAL		BARTON MANAGEMENT INC.		377	377	18
19	V	26	INSURANCE		BARTON MANAGEMENT INC.		145	145	19
20	V	27	EMP. BEN. GEN. ADMIN		BARTON MANAGEMENT INC.		2,010	2,010	20
21	V	33	REAL ESTATE TAXES		BARTON MANAGEMENT INC.		4,875	4,875	21
22	V	34	RENT OFFICE SPACE		BARTON MANAGEMENT INC.		17,167	17,167	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	RENT	30,000	BARTON MANAGEMENT INC.			(30,000)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 30,000			\$ 28,780	\$ * (1,220)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$	BARTON HEALTHCARE LLC	100.00%	\$ 418	\$ 418	15
16	V	20	DUES, SUBSCRIPTIONS		BARTON HEALTHCARE LLC		34	34	16
17	V	32	INTEREST		BARTON HEALTHCARE LLC		186,395	186,395	17
18	V								18
19	V								19
20	V								20
21	V	32	INTEREST	165,976	BARTON HEALTHCARE LLC			(165,976)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 165,976			\$ 186,847	\$ * 20,871	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Leon Shlofrock	Stockholder	Administrative	6.29%	See Attached	9	18.00%		\$		1
2	John Shlofrock	Stockholder	Administrative	5.52%	See Attached	5	10.42%	Facility	56,666	17-1	2
3	Joe Magit	Stockholder	Administrative	14.29%	See Attached	10	28.57%	Facility	90,000	17-1	3
4	Elisa Shlofrock-Zusman	Stockholder	Clerical	5.52%	See Attached	6	14.29%	Facility	10,334	21-1	4
5	Jean Sclofrock	Relative	Clerical	0	See Attached	8	20.00%	Facility	10,333	21-1	5
6	David Becker	Stockholder	Administrative	9.52%	0	1	2.86%	Director Fees	30,000	18-3	6
7	Joe Magit	Stockholder	Administrative	14.29%	See Attached	10	28.57%	Director Fees	30,000	18-3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 227,333		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLAYTON RESIDENTIAL HOME # 0016634 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLAYTON RESIDENTIAL HOME # 0016634 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization BARTON MANAGEMENT INC.  
Street Address 465 CENTRAL AVE.  
City / State / Zip Code NORTHFIELD, IL 60093  
Phone Number ( 847) 441-8200  
Fax Number ( 847) 441-0800

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	194,550	8	\$ 9,250	\$	33,250	\$ 1,581	1
2	6	REPAIRS AND MAINT.	RENTAL INCOME	194,550	8	15,313		33,250	2,617	2
3	20	DUES, FEES, SUBSCRIPTIONS	RENTAL INCOME	194,550	8	48		33,250	8	3
4	21	CLERICAL AND GENERAL	RENTAL INCOME	194,550	8	2,205		33,250	377	4
5	26	INSURANCE	RENTAL INCOME	194,550	8	847		33,250	145	5
6	27	EMP. BEN. GEN. ADMIN	RENTAL INCOME	194,550	8	11,760		33,250	2,010	6
7	33	REAL ESTATE TAXES	RENTAL INCOME	194,550	8	28,523		33,250	4,875	7
8	34	RENT OFFICE SPACE	RENTAL INCOME	194,550	8	100,446		33,250	17,167	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 168,392	\$		\$ 28,780	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLAYTON RESIDENTIAL HOME # 0016634 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization BARTON HEALTHCARE LLC  
Street Address 465 CENTRAL AVE.  
City / State / Zip Code NORTHFIELD, IL 60093  
Phone Number ( 847) 441-8200  
Fax Number ( 847) 441-0800

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8  Facility Units	9  Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	29	7	\$ 2,460	\$	5	\$ 418	1
2	20	DUES, SUBSCRIPTIONS	NOTE RECEIVABLE	29	7	200		5	34	2
3	32	INTEREST	NOTE RECEIVABLE	29	7	1,096,002		5	186,395	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,098,662	\$		\$ 186,847	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLAYTON RESIDENTIAL HOME # 0016634 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLAYTON RESIDENTIAL HOME # 0016634 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number CLAYTON RESIDENTIAL HOME # 0016634 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLAYTON RESIDENTIAL HOME # 0016634 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLAYTON RESIDENTIAL HOME # 0016634 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLAYTON RESIDENTIAL HOME # 0016634 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CLAYTON RESIDENTIAL HOME # 0016634 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Barton Healthcare LLC	X		Mortgage	\$20,833.00	01/27/95	\$ 5,000,000	\$ 2,750,032			\$ 186,395	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Barton Healthcare LLC	X		Shareholder				250,000			30,046	6	
7												7	
8												8	
9	TOTAL Facility Related				\$20,833.00		\$ 5,000,000	\$ 3,000,032			\$ 216,441	9	
	B. Non-Facility Related*												
10	See Supplemental Schedule											10	
11	Interest Income										(25,886)	11	
12	Dividend Income										(52,754)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (78,640)	14	
15	TOTALS (line 9+line14)						\$ 5,000,000	\$ 3,000,032			\$ 137,801	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$	0	Line #

\* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.**  
**(See instructions.)**

**\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
6													6
7													7
8													8
9													9
10													10
11													11
12													12
13													13
14													14
15													15
16													16
17													17
18													18
19													19
20													20
21							\$		\$			\$	21

**SEE ACCOUNTANTS' COMPILATION REPORT**



IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates    RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

CLAYTON RESIDENTIAL HOME

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0016634

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	14-33-208-008-0000	Long Term Care Property	\$ 232,149.25	\$ 232,149.25
2.	Barton Management Allocation	See Attached	\$ 57,046.15	\$ 4,874.80
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 289,195.40	\$ 237,024.05

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    X    YES       NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

CLAYTON RESIDENTIAL HOME

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0016634

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( )

FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?      YES      NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

## X. BUILDING AND GENERAL INFORMATION:

**A. Square Feet:** 57,604 **B. General Construction Type:** Exterior Frame **Number of Stories** 5

**C. Does the Operating Entity?** ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

**(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)**

**D. Does the Operating Entity?** ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

**(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)**

**E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).**

None

**F. Does this cost report reflect any organization or pre-operating costs which are being amortized?** ☐ YES ☐ NO  
If so, please complete the following:

<b>1. Total Amount Incurred:</b>	<b>2. Number of Years Over Which it is Being Amortized:</b>
----------------------------------	---

### 3. Current Period Amortization: 4. Dates Incurred:

### Nature of Costs:

**(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)**

## XI. OWNERSHIP COSTS:

### A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		17,608		\$ 19,250	1
2					2
3	TOTALS	17,608		\$ 19,250	3

**SEE ACCOUNTANTS' COMPILATION REPORT**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1967	\$ 255,750	\$	35	\$	\$	\$ 240,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1969	591,996		20	-		591,996	9
10	Various			1971	1,150		20	-		732	10
11	Various			1972	86,256		20	-		58,370	11
12	Various			1975	15,890		20	-		14,000	12
13	Various			1978	11,746		20	-		11,746	13
14	Various			1979	9,036		20	-		9,036	14
15	Various			1980	45,469		20	-		44,529	15
16	Various			1981	17,720		20	-		17,720	16
17	Various			1982	718		20	-		718	17
18	Various			1983	57,392		20	2,869	2,869	56,118	18
19	Various			1984	48,928		20	2,237	2,237	43,458	19
20	Various			1985	100,852		20	4,086	4,086	93,877	20
21	Various			1986	156,306		20	8,194	8,194	138,127	21
22	Various			1987	25,101		20	1,137	1,137	19,127	22
23	Various			1988	16,259		20	711	711	12,500	23
24	Various			1989	23,627		20	1,242	1,242	16,615	24
25	Various			1990	183,167		20	8,421	8,421	106,288	25
26	Various			1991	53,962		20	2,700	2,700	31,488	26
27	Various			1992	158,472		20	7,923	7,923	89,107	27
28	Various			1993	79,548		20	3,977	3,977	37,652	28
29	Various			1994	105,602		20	5,281	5,281	45,423	29
30	Various			1995	221,995		20	11,099	11,099	85,366	30
31	Various			1996	237,569		20	11,880	11,880	76,038	31
32	Various			1997	81,461		20	4,074	4,074	21,629	32
33	Various			1998	159,916		20	7,996	7,996	38,282	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)								68
69	Financial Statement Depreciation			103,894			(103,894)		69
70	TOTAL (lines 4 thru 69)		\$ 2,745,888	\$ 103,894		\$ 83,827	\$ (20,067)	\$ 1,899,942	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,151,701	\$ 103,894		\$ 104,124	\$ 230	\$ 1,964,464	1
2	WINDOWS (258)	2000	102,920		20	5,146	5,146	14,152	2
3	FIRE DAMPER	2000	4,325		20	216	216	576	3
4	MAINT RM RENOVATE	2000	2,900		20	145	145	387	4
5	DOOR FRAME	2000	1,864		20	93	93	240	5
6	SEWER LINE	2000	12,564		20	628	628	1,622	6
7	A/C INSTALLATION	2000	42,000		20	2,100	2,100	5,250	7
8	SEWER/WATER LINE	2000	3,082		20	154	154	372	8
9	CARPETING	2000	6,959		20	348	348	841	9
10	TILE	2000	1,800		20	90	90	218	10
11	EMERGENCY LIGHTS	2000	3,496		20	175	175	408	11
12	CARPETS	2000	1,011		20	51	51	119	12
13	REMODEL 1ST FLR HALL	2001	12,400		20	318	318	623	13
14	REMODEL WALLS BY ELE	2001	3,400		20	87	87	163	14
15	INSTALL LIGHT FIXTUR	2001	5,464		20	140	140	263	15
16	EXIT DEVICE	2001	1,567		20	40	40	75	16
17	REMODELING NURSES ST	2001	1,967		20	50	50	90	17
18	REMODELING DINING RM	2001	1,200		20	31	31	56	18
19	REMODELING DINING RM	2001	1,200		20	31	31	56	19
20	REMODELING 1ST FLR H	2001	700		20	18	18	32	20
21	VACUUM PUMPS & MISC	2001	110,500		20	2,833	2,833	5,076	21
22	COMPRESSOR	2001	2,459		20	63	63	102	22
23	CARPETING	2001	5,261		20	135	135	208	23
24	RECONTROLLING CARRIE	2001	6,090		20	156	156	241	24
25	CHIMNEY REPAIR	2001	8,830		20	226	226	330	25
26	CERAMIC TILES	2001	535		20	14	14	20	26
27	FLOORING	2001	2,109		20	54	54	74	27
28	INSTALL FLOORING	2001	2,939		20	75	75	103	28
29	HANDRAILS, ENDCAPS	2001	5,162		20	132	132	182	29
30	INSTALL HANDRAILS	2001	1,700		20	44	44	61	30
31	PLUMBING	2001	714		20	18	18	23	31
32	PLUMBING	2001	1,215		20	31	31	40	32
33	PLUMBING	2001	2,878		20	74	74	89	33
34	TOTAL (lines 1 thru 33)		\$ 3,512,912	\$ 103,894		\$ 117,840	\$ 13,946	\$ 1,996,556	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,512,912	\$ 103,894		\$ 117,840	\$ 13,946	\$ 1,996,556	1
2	FLOORING	2001	742		20	19	19	21	2
3	INSTALL FLOORING	2001	13,601		20	349	349	393	3
4	RM MONITOR SYSTM-MAI	2001	1,540		20	39	39	41	4
5	ELECTRICAL WORK	2002	17,000		20	1,700	1,700	1,700	5
6	PUMP-SPRINKLER SYSTEM	2002	3,806		20	127	127	127	6
7	EVAPORATOR-WAL-IN COOLER	2002	2,504		20	83	83	83	7
8	BROKEN TILES REPLACED	2002	7,200		20	240	240	240	8
9	RADIATORS-RETURN LINE	2002	3,885		20	65	65	65	9
10	INSPECT SEWER LINE	2002	480		20	8	8	8	10
11	RODDING OF ADM BATHROOM	2002	250		20	4	4	4	11
12	CLEAR SEWER LINE	2002	210		20	4	4	4	12
13	INSIDE EXCAVATION	2002	6,200		20	103	103	103	13
14	CONTINUING EXCAVATION	2002	6,238		20	52	52	52	14
15	CONTINUING EXCAVATION	2002	3,914		20	33	33	33	15
16	EXCAVATION-GROUT INJECTION	2002	24,105		20	201	201	201	16
17	DIG SITE-DIRT REMOVAL	2002	624		20	5	5	5	17
18	EXCAVATE-REPLACE SEWER	2002	4,786		20	40	40	40	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,609,997	\$ 103,894		\$ 120,912	\$ 17,018	\$ 1,999,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$3,609,997	\$103,894		\$120,912	\$17,018	\$1,999,676	1
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4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,609,997	\$103,894		\$120,912	\$17,018	\$1,999,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$3,609,997	\$103,894		\$120,912	\$17,018	\$1,999,676	1
2									2
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4									4
5									5
6									6
7									7
8									8
9									9
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,609,997	\$103,894		\$120,912	\$17,018	\$1,999,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,609,997	\$ 103,894		\$ 120,912	\$ 17,018	\$ 1,999,676	1
2									2
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4									4
5									5
6									6
7									7
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33									33
34	TOTAL (lines 1 thru 33)		\$ 3,609,997	\$ 103,894		\$ 120,912	\$ 17,018	\$ 1,999,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,609,997	\$ 103,894		\$ 120,912	\$ 17,018	\$ 1,999,676	1
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4									4
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,609,997	\$ 103,894		\$ 120,912	\$ 17,018	\$ 1,999,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,609,997	\$ 103,894		\$ 120,912	\$ 17,018	\$ 1,999,676	1
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4									4
5									5
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,609,997	\$ 103,894		\$ 120,912	\$ 17,018	\$ 1,999,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$3,609,997	\$103,894		\$120,912	\$17,018	\$1,999,676	1
2									2
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4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,609,997	\$103,894		\$120,912	\$17,018	\$1,999,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$3,609,997	\$103,894		\$120,912	\$17,018	\$1,999,676	1
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3									3
4									4
5									5
6									6
7									7
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9									9
10									10
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,609,997	\$103,894		\$120,912	\$17,018	\$1,999,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$512,184	\$	\$29,132	\$29,132	10	\$379,815	71
72	Current Year Purchases	16,097		662	662	10	662	72
73	Fully Depreciated Assets	308,203				10	308,203	73
74								74
75	TOTALS	\$836,484	\$	\$29,794	\$29,794		\$688,680	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1999 FORD E350	2002	\$14,521	\$	\$1,556	\$1,556	5	\$1,556	76
77										77
78										78
79										79
80	TOTALS			\$14,521	\$	\$1,556	\$1,556		\$1,556	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,480,252	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$103,894	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$152,262	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$48,368	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,689,912	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YESNO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Barton Management Allocatoin				17,167			5
6	Storage Rental				194			6
7	TOTAL				\$ 17,361			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease.

9. Option to Buy: YES NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ 20,261 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning  
Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$  
13. /2004 \$  
14. /2005 \$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	99 Ford Passenger	\$ 595.00	\$ 1,785	17
18					18
19					19
20					20
21	TOTAL		\$ 595.00	\$ 1,785	21

\* If there is an option to buy the building,  
please provide complete details on attached  
schedule.

\*\* This amount plus any amortization of lease  
expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,332,390	\$	1
2	Cash-Patient Deposits	7,363		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,609,059		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	996,590		5
6	Prepaid Insurance	99,605		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	83,112		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,128,119	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	19,250		13
14	Buildings, at Historical Cost	255,750		14
15	Leasehold Improvements, at Historical Cost	3,067,738		15
16	Equipment, at Historical Cost	1,023,204		16
17	Accumulated Depreciation (book methods)	(2,549,573)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	1,265		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,817,634	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,945,753	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 157,633	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	250,000		29
30	Accrued Salaries Payable	157,434		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,221		31
32	Accrued Real Estate Taxes(Sch.IX-B)	239,114		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	11,595		35
	<b>Other Current Liabilities(specify):</b>			
36	See Supplemental Schedule	7,661		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 837,658	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,750,032		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Supplemental Schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,750,032	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,587,690	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,358,063	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,945,753	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,228,727	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,228,727	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,279,336	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,150,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 129,336	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,358,063	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 8,521,407	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,521,407	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	78,640	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 78,640	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	2,193	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,193	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,602,240	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,470,411	31
32	Health Care	2,078,642	32
33	General Administration	2,905,139	33
	<b>B. Capital Expense</b>		
34	Ownership	638,319	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	92,423	35
36	Provider Participation Fee	137,970	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,322,904	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,279,336	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,279,336	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number     CLAYTON RESIDENTIAL HOME

#   0016634

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 60,154	\$ 28.92	1
2	Assistant Director of Nursing	2,000	2,166	51,693	23.87	2
3	Registered Nurses	10,304	10,826	395,651	36.55	3
4	Licensed Practical Nurses	10,087	10,581	194,324	18.37	4
5	Nurse Aides & Orderlies	66,629	71,605	629,146	8.79	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,044	14,150	119,134	8.42	10
11	Social Service Workers	30,174	32,163	447,586	13.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,081	24,319	206,004	8.47	15
16	Dishwashers					16
17	Maintenance Workers	9,437	10,232	119,337	11.66	17
18	Housekeepers	32,444	35,010	299,935	8.57	18
19	Laundry					19
20	Administrator	2,000	2,080	89,961	43.25	20
21	Assistant Administrator	2,000	2,166	38,376	17.72	21
22	Other Administrative	4,828	4,828	185,365	38.39	22
23	Office Manager					23
24	Clerical	53,394	56,561	588,195	10.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,169	2,368	34,119	14.41	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	256,763	276,307	\$ 3,458,980 *	\$ 12.52	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	260	\$ 12,750	01-03	35
36	Medical Director	104	2,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	2,120	63,236	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,580	\$ 80,186		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	708	9,381	10-03	52
53	TOTAL (lines 50 - 52)	708	\$ 9,381		53

SEE ACCOUNTANTS' COMPILATION REPORT

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Barbara Thomas (01/01-12/31/02)	Administrator	0	\$ 89,961	Workers' Compensation Insurance	\$	67,145	IDPH License Fee	\$
Darrell Roundtree (01/01-12/31/02)	Asst. Adminstrator	0	38,376	Unemployment Compensation Insurance		17,195	Advertising: Employee Recruitment	
John Shlofrock	Administrative	5.52%	56,666	FICA Taxes		242,410	Health Care Worker Background Check	620
Marla Coquette	Administrative	0	53,750	Employee Health Insurance		202,522	(Indicate # of checks performed 87 )	
Jean Schlofrock	Administrative	0	10,333	Employee Meals		9,928	Dues & Subscriptions	422
Rick Duros	Administrative	0	32,356	Illinois Municipal Retirement Fund (IMRF)*			Licenses & Fees	1,410
Gary Weintraub	Administrative	0	32,260	Chicago Head Tax		5,379	Promotional Advertising	11
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Benefits		10,468	Classified Advertising	4,111
(List each licensed administrator separately.)			\$ 313,702	Employee Uniform		1,139	Dues-ICLTC	9,431
B. Administrative - Other				Employee Benefit Plan		2,547	Barton Management Allocation	42
Description			Amount				Less: Public Relations Expense	(11)
Management Fees			\$ 858,190				Non-allowable advertising	( )
							Yellow page advertising	( )
				TOTAL (agree to Schedule V,	\$	558,732	TOTAL (agree to Sch. V,	\$ 16,036
				line 22, col.8)			line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 858,190	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type							
FR&R	Accounting	\$	17,510			\$	Out-of-State Travel	\$
Barton Mgmt	Allocation		714					
Pension Performance	Accounting		2,325					
Alpha Data Services	Data Processing		3,950				In-State Travel	
Accumed	Data Processing		500					
Barton Mgmt	Data Processing		6,107					
Omnicare	Data Processing		500					
Jacobs Healthcare	Data Processing		100				Seminar Expense	1,492
Personel Planners	Unemployment Consultant		1,170		87			
Adjusted Out on Page 5	Risk Management		6,000					
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 38,876				line 24, col. 8)	\$ 1,492

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Painting & Decorating	2002	\$ 3,312	3	\$	\$	\$	\$ 552	\$ 1,104	\$ 1,104	\$ 552	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
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16													
17													
18													
19													
20	TOTALS		\$ 3,312		\$	\$	\$	\$ 552	\$ 1,104	\$ 1,104	\$ 552	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		CLAYTON RESIDENTIAL HOME		STATE OF ILLINOIS				Page 23
		#	0016634	Report Period Beginning:	01/01/02	Ending:	12/31/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount.

Yes  
IL Council on LTC - \$13508.52

(3)

Did the nursing home make political contributions or payments to a political action organization?  
If YES, have these costs been properly adjusted out of the cost report?

Yes  
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?  
What was the average life used for new equipment added during this period?

Yes  
10 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 0 Line N/A

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?  
If YES, give effective date of lease.

No  
Yes

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X  
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.  
This amount is to be recorded on line 42 of Schedule V.

\$ 137,970

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  
If YES, attach an explanation of the allocation.

No

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

No

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?  
For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.  
Has any meal income been offset against related costs?

\$ 9,928  
No  
Indicate the amount. \$ N/A

(16)

Travel and Transportation  
a. Are there costs included for out-of-state travel?  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents?  
If YES, please indicate the amount of income earned from such a program during this reporting period.  
c. What percent of all travel expense relates to transportation of nurses and patients?  
d. Have vehicle usage logs been maintained?  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No  
No  
N/A  
Yes  
No  
Yes

g. Does the facility transport residents to and from day training?  
Indicate the amount of income earned from providing such transportation during this reporting period.

No  
\$

(17)

Has an audit been performed by an independent certified public accounting firm?  
Firm Name:  
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?  
If no, please explain.

No

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?  
Attach invoices and a summary of services for all architect and appraisal fees

Yes

SEE ACCOUNTANTS' COMPILATION REPORT